Experiences of Māori of Aotearoa New Zealand's public health system: a systematic review of two decades of published qualitative research

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Aotearoa New Zealand's publicly funded, universal health system incorporates free inpatient and outpatient public hospital services, subsidies on prescription items, subsidised primary healthcare and a range of support services for people with disabilities in the community. However, this publicly funded health service is designed to privilege individualistic approaches, clinical discourses and acute need.[1] This form of service provision disadvantages Māori, the Indigenous people of Aotearoa New Zealand. Prior to colonisation, Māori had developed health structures and systems tailored to themselves, their environment and collective concepts of health.[2] Colonisation fundamentally disrupted these systems, with newly imposed health systems (including hospitals) configured primarily to serve Pākehā (New Zealanders of European descent).[3] Inequitable Māori healthcare outcomes are consistent with broader Indigenous experiences of colonisation that include theft of land, degradation of language, racist policies, discrimination and social exclusion.[4] Practices associated with colonisation include reduced access to social determinants of health,[5] higher rates of preventable, adverse in-hospital events,[6] and increased likelihood of inappropriate care and follow-up.[7,8] (Davis et al.[6] defined a preventable adverse event as an unintended injury that resulted in disability or death, with evidence of an error by healthcare management due to failure to follow accepted practice.) Māori patients typically receive inequitable access to interventions and quality of care[9,10]

and consistently report negative hospital experiences.[11,12] Correspondingly, Māori families accessing hospital care for a child encounter systemic barriers.[13] Biomedical and reductionist models that focus on presenting symptoms dominate health research approaches,[14,15] and the experiences of marginalised groups are subsumed into dominant individualistic, colonial narratives.[15] In short, Māori healthcare needs are not being met.

The aim of this paper is to synthesise the broader perspectives of Māori patients and whānau (extended family, family group) within this publicly funded system. The

following research question guided our review: 'What are the experiences of Māori in the public health and/or hospital system in Aotearoa New Zealand?' This review also contributes to a Health Research Council of New Zealand-funded project: 'Does a Whānau Ora approach improve outcomes for hospitalised tamariki (children)?', which aims to document the impact of utilising a screening tool (Harti) in a culturally appropriate way. With a view to reducing hospital readmissions, the Harti tool integrates health, education, and social services in order to improve equity of access to existing services, ensure high-quality

Abstract

Objective: This paper aims to synthesise the broader perspectives of Māori patients and their whānau (extended family, family group) of their treatment within the public health system. Our research question was 'What are the experiences of Māori in the public health and/or hospital system in Aotearoa New Zealand?'

Methods: A systematic search using PRISMA protocols and reflexive typology organised around the categories of Māori, public healthcare and qualitative research identified 14 papers that covered all three categories. We undertook a qualitative metasynthesis on these papers using a critical community psychology approach.

Results: Māori patients and whānau from the included papers mention both barriers and facilitators to health. We categorised barriers as organisational structures, staff interactions and practical considerations. Facilitators were categorised as the provision of whānau support in the form of practical assistance, emotional care and health system navigation.

Conclusions: For many Māori, the existing public health system is experienced as hostile and alienating. Whānau members provide support to mitigate this, but it comes as a cost to whānau.

Implications for public health: Public health providers must find ways to ensure that Māori consistently experience positive, high-quality healthcare interactions that support Māori ways of being.

Key words: Indigenous health, healthcare barriers, inequities, whānau, institutional racism

and culturally appropriate interactions, and showcase how incorporating Kaupapa Māori practice into service delivery improves outcomes. Kaupapa Māori refers to the knowledge, skills, attitudes and values underpinning and guiding Māori society. Conducting a systematic review provides an opportunity to examine the breadth and depth of Māori experiences over a 20-year period. Aware that such works are not commonly published, we have intentionally given primacy to the perspectives and experiences of Māori patients and their whānau. By their nature, qualitative studies focus on the experiences of smaller, discrete groups, and facilitate deeper understanding of the context under examination.[16] As a result, we are able to elevate the lived experience of Māori.

Methods

Qualitative metasyntheses are an ideal method for considering broader experiences of healthcare[16] and represent a valuable approach for systematic reviews in social and health disciplines.[17] A qualitative metasynthesis provides tools for integrating and analysing findings in ways that produce new knowledge and understandings in a substantive area.[18] We employed a structured approach alongside PRISMA protocols and reflexive dialogue.[16] The review process involved a systematic literature search, screening articles for relevance to the research question, selection and appraisal of studies, and analysis and synthesis of findings.

Systematic literature search and screening process

We used systematic procedures to search the University of Waikato's database, Scopus and Sage for English-language articles published 2000–2018 that were qualitative in approach and focused on the experiences of Māori within the Aotearoa New Zealand health system. Collections searched from the University of Waikato were: Scopus (Elsevier), ProQuest Central (new), Wiley Online Library, ABI/INFORM Complete, SAGE Journals, ScienceDirect Journals (Elsevier), Sociological Abstracts, Taylor & Francis Online – Journals, Social Services Abstracts, PMC (PubMed Central), Informit Health (RMIT), SpringerLink, Directory of Open Access Journals (DOAJ), ERIC (U.S. Dept. of Education), Informit Business (RMIT), Cambridge Journals (Cambridge University Press), Emerald Insight, Oxford Journals (Oxford University Press), SpringerLink Open Access, and JSTOR Archival Journals. The limited capacity of the University of Waikato's database search function did not give us confidence that archives were sufficiently included, hence subsequent searches in Scopus and Sage. Scopus had capacity for multiple interrelated search requests across peer-reviewed journals, while Sage provided refined ability to specifically search articles published in *AlterNative: An Indigenous Journal of Indigenous Peoples*. (*AlterNative* is the leading journal publishing Māori-based research articles. It is not sufficiently included within Scopus; only publications from 2014 and 2016–18 are included as source material in Scopus.)

The systematic search was organised around four categories: Māori, qualitative research, personal experience and public healthcare (see Table 1). Inclusion criteria were: 1) a focus on perspectives of Māori patients and their whānau; 2) a focus on experiences of physical health treatment within the public health system of Aotearoa New Zealand; and 3) utilisation of qualitative methods. We focused on the experiences of physical health because the wider study within which this review is located ('Does a Whānau Ora approach improve outcomes for hospitalised tamariki?') aims to document the impact of a screening tool (Harti) that integrates health, education and social services for tamariki Māori (children of Māori descent) and their whānau. The wider study does not have a pathway for mental health support; therefore, we did not include such studies in our systematic review. Exclusion criteria were: 1) published prior to 2000; 2) focused on end-of-life care; and 3) focused on theoretical discussions and practitioner perspectives. We excluded end-of-life care because hospices and families provide care in Aotearoa New Zealand outside of the publicly funded hospital system.

Study selection and appraisal

The University of Waikato's database yielded 318 potential studies. Using filters to exclude non-New Zealand-based research, studies not focused on physical health treatment, and

Table 1: Search terms and results.		
University of Waikato	**Search terms (Journal articles, English, published 2000-2018)**	**Articles (n)**
Search 1	TI contains Māori OR Maori OR New Zealand	89,051
Search 2	TI contains Narrative OR Ethno* OR Interpretative OR Interview* OR Mixed method* OR Qualitative OR Thematic OR Theme*	194,093
Search 3	TI contains Experience*OR Perspective* OR Attitude* OR Belief* OR Opinion* OR Perception* OR Value*	498,957
Search 4	TI contains Hospital* OR Health* OR Outpatient* OR Inpatient* OR Emergency Care	861,460
Search 5[a]	TI contains Māori OR Maori OR New Zealand AND TI contains Health* OR Hospital* AND TI contains Experience* OR Perspective* OR Value* OR Belief*	318
Search 6	Filter: Exclude Australia, Oceanic Ancestry Group, Mental Health, Depression	197
Scopus	**Search terms**	**Articles (n)**
Search 1	TI, AB, KY contain Māori OR Maori OR New Zealand	160,286
Search 2	TI, AB, KY contain Narrative OR Ethno* OR Interpretative OR Interview* OR Mixed method* OR Qualitative OR Thematic OR Theme*	717,683
Search 3	TI, AB, KY contain Experience*OR Perspective* OR Attitude* OR Belief* OR Opinion* OR Perception* OR Value*	9,556,067
Search 4	TI, AB, KY contain Hospital* OR Health* OR Outpatient* OR Inpatient* OR Emergency Care	2,225,196
Search 5	S1 + S2 + S3 + S4	1051
Search 6	Filter: Journal articles, English, published after 1998	666
Search 7	Filter: Keyword Maori	42
AlterNative	**Search terms**	**Articles (n)**
Search 1[b]	ALL Māori OR Maori OR New Zealand AND ALL Hospital* OR Health*	34

Notes:

a: The University of Waikato library search function was unable to perform a S1 + S2 + S3 + S4 search, requiring search terms to be simplified.

b: Search function unable to process multiple variables requiring search terms to be simplified

end-of-life care reduced these to 197 studies. The Scopus search yielded 666 potential studies. Filtering by Keyword 'Māori' reduced this to 42. The Sage search of *AlterNative* yielded 34 studies. Together, 273 articles were reviewed by title and abstract; 238 of these were excluded. Removing duplicates left 36 studies. Subsequent to a full-text assessment and the appraisal process (see below), a further 22 studies were excluded, leaving 14 research articles that fully met our inclusion criteria (see Figure 1).

As with Mbuzi et al.[19] we did not use the Critical Appraisal Skills Programme (CASP) checklist for appraising qualitative research as it prioritises dominant colonial-based expectations of methods, irrespective of academic contributions.[17] Further, such checklists typically focus on procedural aspects pertaining to Western (positivist) paradigms, disregard Kaupapa Māori methods and overlook contributions to Mātauranga Māori (Māori knowledge). In particular, they are an inappropriate tool for assessing Kaupapa Māori-based research (which many of our included studies draw on), given the historic use of 'rigor' to delegitimise Māori perspectives and experiences;[20] even so-called 'low-quality' articles can offer highly relevant and useful information.[17,21] Instead, we drew on Sandelowski and Barroso's[16] typology of qualitative appraisal, which involved several readings of each of the potential articles to become acquainted with the content. This 'reflexive dialogue'[18] approach to appraisal is more congruent with our Kaupapa Māori and community psychology orientation. All 14 of the included qualitative studies contribute valuable, high-quality information regarding Māori experiences of healthcare provision.

Analytical approach

We used a critical community psychology approach[22] to thematic analysis.[23] Our iterative process[24] involved independent analysis followed by robust, collaborative discussion, including oral presentations and subsequent conversations with stakeholder groups. From this process, we developed codes and themes relevant to our research aim. In our analysis, we firstly considered all included quotes from the original participants, then the original authors' summations and interpretations, and, lastly, the entire research corpus across the timeframe of all 14 studies. Throughout, our process centred te Ao Māori (the world

Figure 1: Flowchart of selection process.
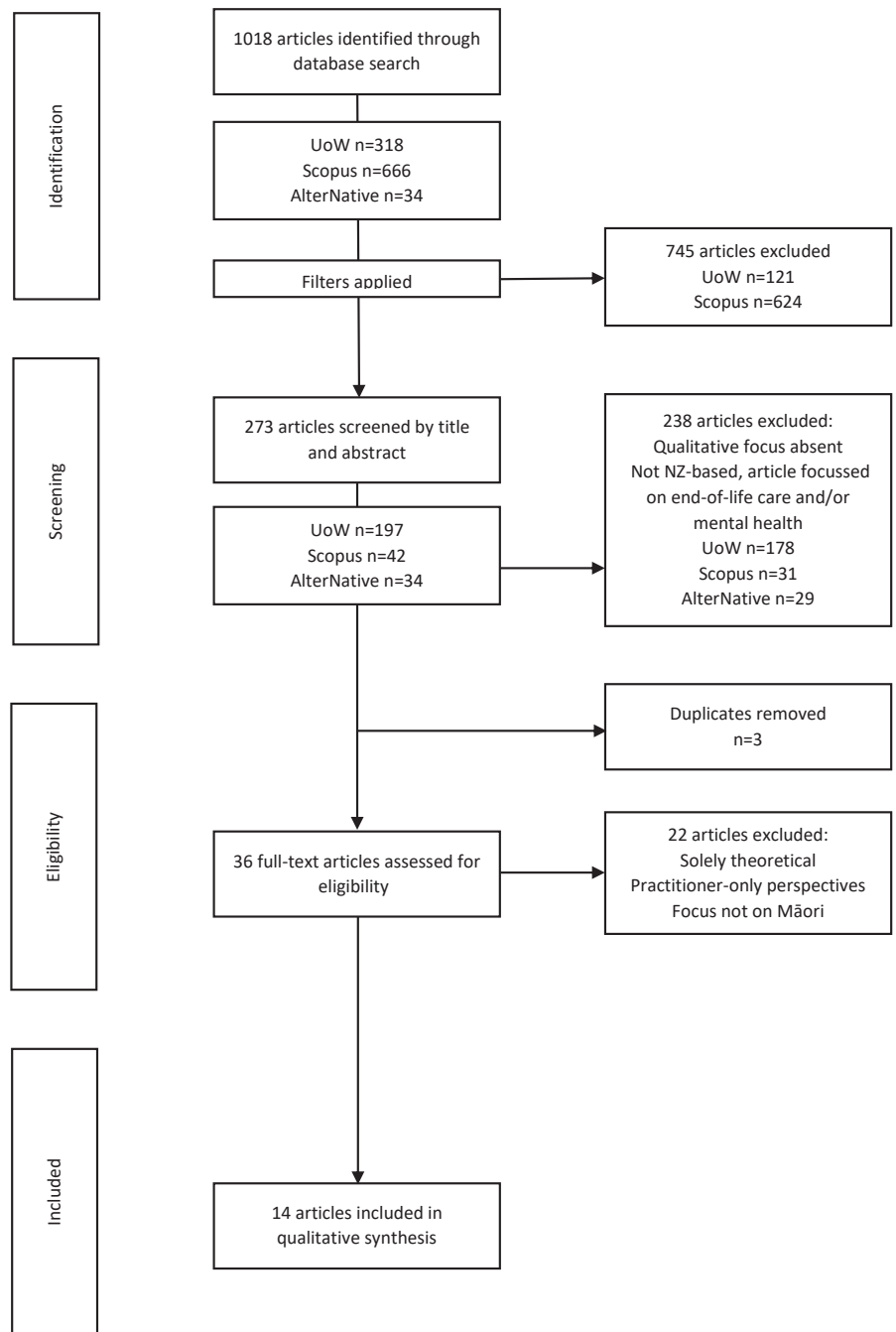
of Māori). Our method of systematically moving through each process moved our analysis beyond simplistic explanations into a wider consideration of the complexities of culture and avoided perpetuating known problems invisible to dominant groups.[25] The authors of this article are Māori (BMA) and Pākehā (RG), and are grounded in a community psychology orientation that values health equity, social justice and community wellbeing.[25] As tangata whenua (local Indigenous person) and tauiwi (non-Māori person), we bring together te Ao Māori

and the Pākehā world in considering and interpreting the research corpus, and how we might re-imagine public health systems to ensure equity of health outcomes.

Results

Our systematic processes reduced 1,018 identified articles to 14 appropriate for use in this review (see Figure 1). The studies included in our metasynthesis (see Table 2) had responses recorded from 372 participants. (Articles by Penney et al. (2011)

Table 2: Included articles of Māori experiences of hospital and healthcare in Aotearoa New Zealand.

Author, Year	Aim	Research approach	Methods	Participants	Region	Analytical approach
Arlidge et al., 2009	To explore and describe the experiences of indigenous Māori and Pacific families and Pakehā families when their children were admitted to hospital for an unintended injury	Kaupapa Māori-informed	Face-to-face individual interviews; group interviews	23 children and their family/whānau	Auckland	Thematic, comparative
Gilmour, Huntington & Robson, 2016	To explore the oral health experiences of Māori with dementia and their whānau	Descriptive	Semi-structured face-to-face interviews	5 people with dementia; 12 whānau members	Doesn't say, rurally-based	Thematic, descriptive
Kerr, Penney, Moewaka-Barnes & McCreanor, 2010	To improve healthcare practice and Māori access to healthcare for management of ischaemic heart disease	Action Research	Face-to-face interviews; Series of hui (focus groups); Follow-up interviews	25 Māori with ischaemic heart disease; stakeholder organisations; 19 health workers	Te Tai Tokerau (Northland)	Thematic, descriptive
Kidd et al., 2013	To explore the views of Māori men (and their whānau) who have a chronic disease or cancer	Kaupapa Māori	Semi-structured face-to-face interviews	47 Māori men aged 40-82; 15 whānau members	Midland Health	Thematic, iterative, interpretative
Lee & North, 2013	To better understand the experiences of Māori sole mothers' access to health services for their health needs	Kaupapa Māori-informed	Semi-structured face-to-face interviews	7 Māori sole mothers	Auckland	Thematic
Nikora, Hodgetts, Carlson & Rua, 2011	To explore the culturally-patterned nature of medications in 4 Māori households with a chronically-ill member	Multi-faceted, Kaupapa Māori-informed	Face-to-face interviews; photo-production exercises; mapping; diaries	13 participants; 4 households	Hamilton	Thematic, iterative, interpretative
Penney, Moewaka-Barnes & MCreanor, 2011	To examine the ways in which Māori patients and Tauiwi healthcare providers understand and interpret interactions	Critical, Kaupapa Māori-informed	Semi-structured face-to-face interviews	25 Māori patients; 19 health professionals	Te Tai Tokerau (Northland)	Thematic, inductive, discursive
Reid, Cormack & Crowe, 2015	To examine experiences of accessing and engaging with primary healthcare among adult urban Māori	Kaupapa Māori, Cultural health capital	Semi-structured face-to-face interviews	40 Christchurch-based Māori	Christchurch	Thematic, inductive, iterative, interpretative
Slater et al., 2013	To describe the cancer journeys of Māori patients and their whānau, with regards to accessing care	Māori-centred	Semi-structured face-to-face interviews	12 Māori patients and their whānau	Wellington & Wairarapa	Thematic
Stevenson, Filoch, Cram & Lawton, 2016	To explore the birth experiences of young Māori women	Kaupapa Māori	Post-birth face-to-face interviews	16 Māori women under the age of 20	Wellington & Hawkes Bay	IPA
Tinirau, Gillies & Tinirau, 2011	To gain understanding of past health services in a rural community from the perspective of older Māori	Kaupapa Māori; Te Kōhao o te Ngira & Kōriporipo	Face-to-face interviews	63 kuia and koroheke (elderly people) connected to Rānana, Whanganui	Whānganui	Thematic
Walker et al., 2008	To explore Māori experiences of cancer	Kaupapa Māori-informed	Series of 5 hui (focus groups); 8 individual face-to-face interviews	44 Māori from Horowhenua, Manawatu, Tairāwhiti districts	Wairarapa	Thematic, iterative
Willams et al., 2003	To discover Māori men's experiences of health seeking for prostrate health issues	Kaupapa Māori-informed	Face-to-face interviews	20 Māori men	Wellington	Thematic, cross-case
Wilson & Barton, 2012	To explore Māori experiences of hospitalisation in surgical or medical settings	Case study, Māori-centred	Semi-structured face-to-face interviews; NZHIS length-of-stay data	11 Māori who had been hospitalised in the past 15 years	Doesn't say	Thematic, iterative

and Kerr et al. (2010) draw on the same participant set of 25 Māori patients and 19 health professionals from the Te Tai Tokerau (Northland) region. Some studies (n=4) included whānau members, but exact numbers of whānau participating were not given.) Of these 372 participants, 326 were patients, 27 were whānau members of patients and 19 were health workers. Studies spanned locations throughout Aotearoa New Zealand: Northland (n=2), Auckland (n=2), Hamilton/Midlands (n=2), Hawkes Bay, Wairarapa (n=2), Whānganui (n=1), Wellington (n=3) and Christchurch (n=1). Gilmore et al.[26] interviewed rurally located Māori and whānau members, while Wilson and Barton[27] interviewed previous patients from across DHBs. The specific health issues studied were: birth (n=2), cancer (n=3), chronic illness (n=2), general care (n=4), ischaemic heart disease (n=1), oral health (n=1), prostrate health (n=1) and unintentional injury (n=1). The Health Research Council of New Zealand fully- or part-funded 10 of the 14 included studies. Findings are categorised into barriers and facilitators of health, which are discussed in turn below.

Barriers to health

Māori patients and their whānau from across the 14 included studies describe two decades of negative health experiences and make a compelling argument for the negative impacts of colonial-led health services on Māori health outcomes. Descriptions of barriers to healthcare encompass difficult experiences described by the original participants. Overall, three core threads were identified that, when woven together, estranged Māori patients and their whānau: 1) organisational structure; 2) staff interactions; and 3) practical barriers. Table 3 details this further.

1. Organisational structure

Māori patients and their whānau from the included studies were keenly aware of negative perceptions by health professionals, with differences in body language and facial expressions, whether spoken or not, interpreted as discrimination and perceived as racist: "You're talking about a European doctor. There was a slight difference and a different show on their face".[28] Māori patients also reported more actively hostile experiences, being treated with scepticism,[29] experiences of overt racism

and discrimination – "they interrogate you because you're brown"[27] – and staff mispronunciations of names.[30] These experiences led Māori from the included studies to view health practitioners as uninterested in their health and wellbeing. As well as explicit and implicit experiences of racism and discrimination, Māori patients and whānau felt that their wider spiritual and cultural practices were devalued within the mainstream health system: "The hospital deals with your physical problems but they do not deal with your mental and spiritual problems",[31] and "Get them better, throw them out the door, who cares about their spiritual [health] or whatever".[32] Subsequently, Māori patients felt that they needed to compromise their cultural and spiritual needs in order to receive hospital care, where "everything is done in a kind of Western way".[27] Feeling culturally alienated in this manner contributed to patients feeling anxious and worried while in hospital, resulting in requests for earlier discharge than recommended.[27,30,32] Rongoā (traditional medicinal applications and treatment) was used regularly by Māori patients, sometimes instead of prescribed medications.[27,28,33] However, rongoā use was typically not discussed with doctors as the domination of the biomedical approach to healthcare left little room for traditional practices, leaving patients feeling uncomfortable discussing this with doctors. Instead, Māori patients in the included studies waited until discharge before accessing traditional healing techniques such as rongoā, karakia (incantation, ritual chant), and mirimiri (traditional Māori massage techniques).

2. Staff interactions

Narratives from across the studies (see Table 3) highlighted an inability by clinicians to build rapport and an associated absence of warmth when providing patient care. This absence of relational connection contributed to ongoing negative narratives between patients and health workers. Additionally, having "too many locums"[29] and high staff turnover was "unsettling because it is difficult to build a relationship with a new doctor".[33] Having constantly changing staff was frustrating and upsetting for Māori patients.[30,33,34] Having to repeat themselves multiple times – "Every different one who'd come in, they'd ask you those questions and you've got to go over it again. I was getting sick of getting asked the same questions"[34] –

Table 3: Barriers to health experienced by Māori patients and their whānau.								
First author, Date	Organisational Structure		Staff Interactions			Practical Barriers		
	Racism	Cultural alienation	No relational rapport	Ineffective communication	Rushed staff	Cost	Transport	Time
Arlidge, 2009	√	√		√	√	√	√	√
Gilmour, 2016				√		√	√	√
Kerr, 2010		√	√	√	√			
Kidd, 2013	√	√	v	√		√	√	
Lee, 2013						√	√	√
Nikora, 2011				√		√		√
Penney, 2011	√	√	√	√	√		√	
Reid, 2015	√	√						
Slater, 2013			√	√	√	√	√	
Stevenson, 2016	√	√		√	√	√	√	
Tinirau, 2011						√	√	√
Walker, 2008	√		√	√		√		√
Williams, 2003	√	√	√	√				
Wilson, 2012	√	√		√	√			√

contributed to feelings of alienation and led to inconsistencies in provided care. For Māori patients and whānau facing an uncertain diagnosis in an unfamiliar system, inadequate and inappropriate information provision prevented them from knowing what to ask for. Even where information was provided, it was not always adequately explained: "Sometimes they give you a pamphlet, you don't have the time, and you need someone there to say it out".[30] This lack of information was distressing for whānau – "I was too frightened to ask"[32] – and compounded a sense of mistrust in medical professionals.[27] Māori patients and whānau also had difficulty accessing resources and ancillary support services. The sharing of information appeared to be dependent upon staff knowledge, time and willingness to engage with patients and whānau.[35] It was unclear if staff were unaware of available services, too busy to provide information or not interested in assisting Māori patients. Māori patients and whānau were well-attuned to the stress levels and concerns of health workers. Participants from the reviewed studies reported being hesitant to disturb staff,[30,34] not wanting to "be a nuisance"[32] and being reluctant to insist on receiving much-needed healthcare.[26,29,36] Subsequently, Māori patients minimised their pain and severity of symptoms to avoid "wasting the time of health professionals".[37] This form of self-silencing in order to avoid pressuring staff led to poorer health outcomes for Māori patients.

3. Practical barriers

Overall, low-income whānau typically avoided accessing healthcare for as long as possible, often waiting until it was unavoidable. As outlined in Table 3, low-income participants mentioned financial costs, transportation issues and practicalities such as organising leave and/or childcare as obstacles to accessing clinics, attending appointments and receiving appropriate levels of healthcare. The financial cost of healthcare included fees associated with after-hours medical clinics, prescription co-pays, dental care and the cost of GP visits. Even relatively 'minor' fees were a barrier to access, with low-income sole mothers reporting having to choose between food and healthcare: "That's half of our food for the week to go to a doctor and for me, it's not an option".[38] The travel times required for rurally located patients to access urban centres where healthcare facilities were located was a significant barrier: "One family travelled over 100 kilometres…then endured a long wait with some stressful behaviours needing to be managed".[26] This was particularly so for whānau who relied on others for transport and who "lived some distance from the hospital and had to find their own means of travelling to and from it".[34] Even in urban centres, the financial cost of transport made access difficult. Public transport options were identified as being insufficient or impossible, particularly for new mothers.[34,38] Those in waged work mentioned difficulty in fitting medical appointments around work hours, and were frustrated that medical personnel did not understand the logistical challenges of managing waged work and medical check-ups: "Doctors and educators think we have unlimited sick leave just to see them to answer questions … lately, I've tried to see my

doctor, but she's been too busy".[36] For young Māori mothers, a sense of "disapproval from others in the waiting room regarding the children",[38] alongside insufficient childcare, resulted in going without much-needed primary healthcare.

These barriers to health as experienced by Māori patients and their whānau are not new. This review highlights that these are ongoing experiences prior to and during the review period. Rather than remaining focused on the barriers, we also need to consider factors that facilitate positive health outcomes. In this next section, we focus on the systems, structures, practices and influences that we wish to build on as we move forward.

Facilitating health factors

Our research synthesis highlighted the various ways that whānau and Māori service providers 'bridge the gap' between proffered healthcare and required need. All bar one of the included studies made mention of whānau support and the ways in which this assisted them to manage their health. Mitigating aspects identified across the included studies are presented as facilitating factors (see Table 4). An overarching theme of support comprises three provision areas: 1) practical support: assistance with financial costs, transport and personal care; 2) wellbeing: emotional support that encompasses hauora wairua (spiritual health) and hauora hinengaro (emotional health); and 3) health system navigation: sourcing information, advocacy during care, and managing medications.

1. Practical support

Across all 14 studies in our review, whānau engaged in significant amounts of caring

work, so much so that it was said: "You won't survive if you don't have the support of your whanau".[31] The extent of support provided by whānau was typically unrecognised by health professionals and came at a cost, with whānau members sacrificing time, money and their own emotional wellbeing. The provision of transport to and from hospital and other healthcare appointments placed additional financial and time burdens on already stretched whānau members. Where whānau were unable to provide care due to insufficient finances, transport difficulties, and/or being unable to take leave from work, this caused distress.[31,33] Māori patients felt that hospital staff assumed whānau support would always be available.[27,31,32] In reality, some Māori patients felt isolated and alone.[28,37] Solo Māori mothers in larger urban centres were particularly isolated, with many carrying the full financial and emotional load of care for children in addition to their own healthcare needs.[34,38,39] Where the personal care provided by the health system was deemed inadequate, personal care was managed by whānau members (see Table 3). While patients were grateful for support, there was also anger that "whānau were being treated as menial workers and expected to provide physical care with no remuneration or recognition".[32]

2. Emotional wellbeing

Quotes from the 14 publications described positive interactions as central to their emotional wellbeing while in hospital. This included acknowledgement of the ways that Māori health providers, individual health professionals and whānau support patients to enhance their emotional wellbeing. Relational rapport such as "displaying interest in the

whānau and personal life"[28] and exhibiting qualities such as "compassion, warmth, honesty, [and] respect"[31] had a positive impact on emotional wellbeing. Māori patients responded positively to humour: "I laughed with the nurse",[28] to dignity: "I just expected a little bit of civility and courtesy and I'm happy"[31] and to health workers taking time to "check-in".[37] Consistency of care, along with interacting with one key hospital person, was recognised as having an emotional benefit: "It makes you more relaxed and calm knowing you've got that one person instead of four or five different people looking at you".[34] Overall, where Māori patients had positive relationships with healthcare practitioners and/or someone they trusted in hospital, it made a positive difference to their experiences, engagement and health outcomes.

3. Health system navigation

Navigating the health system on behalf of unwell whānau members is difficult and stressful and requires time, energy and skill. For Māori patients, having a trusted whānau member who could source and interpret information, as well as advocate for their needs, made a positive difference to their health outcomes. Māori patients and their whānau spoke highly of the services they received from Māori health providers. Māori health providers were more affordable,[38] assisted with practicalities such as transport[33] and resulted in improved health outcomes.[37] Aspects such as being able to "talk a little bit more freely",[32] feeling understood,[28] and having a connection with a Māori health professional who was "able to relate"[31] were deeply appreciated. Proffered supports from Māori providers varied, but for those who engaged with their services, they provided warm, holistic, culturally appropriate healthcare that 'filled the gap' where it was needed. Māori health services who provided information and advocacy assistance, or helped manage medications, were typically described as "being like whānau" as they provided "whanaungatanga" (relationship, kinship, sense of family connection),[35] were "just so welcoming"[32] and were given "high praise".[31]

Discussion

These 14 studies covering the past 18 years of Māori experiences of healthcare tell of an alienating public health system. Māori

Table 4: Types of support provided by whānau members and/or service providers for Māori patients.								
First author, Date	Practical Support			Emotional Well-being		Health System Navigation		
	Financial	Transport	Personal care	Wairua	Hinengaro	Information	Advocacy	Medication
Arlidge, 2009	√					√	√	
Gilmour, 2016		√	√			√		
Kerr, 2010						√	√	
Kidd, 2013			√	√	√			
Lee, 2013	√	√					√	
Nikora, 2011	√	√	√					√
Penney, 2011								
Reid, 2015						√	√	
Slater, 2013	√		√	√	√	√	√	
Stevenson, 2016	√	√		√				
Tinirau, 2011				√	√		√	√
Walker, 2008			√	√	√	√	√	√
Williams, 2003				√	√			√
Wilson, 2012		√		√	√	√	√	

patients and their whānau consistently experience barriers between themselves and the health treatment they require (and are legally entitled to). Such experiences are a continuation of ongoing exclusion.[5] Experiences of coldness, micro-aggressions, discriminatory behaviour and shaming communicate a sense of 'not-belonging' and result in Māori patients and whānau disengaging and/or actively avoiding healthcare-related interactions as much as possible. This disengagement is a sensible tactic that works to sustain and maintain one's sense of self when under attack.[40] Dominant group members draw on negative stereotypes of Māori and misinterpret these survival tactics as failure to take responsibility for individual health.[29] This form of structural violence[41] is a tactic of hegemony and is perpetuated by dominant groups. Blaming marginalised groups for their responses to oppression simultaneously works to blame those in receipt of injustice while absolving themselves of their own responsibility for change.[42] Together, these tactics form a powerful act of silencing for Māori patients and their whānau within which disengagement becomes an act of resistance to dominant health hegemonies.

For many Māori in the included studies, healthcare encompasses much more than doctor's visits, medications and treatment plans. Nevertheless, the personal and culturally relevant ways in which they managed their health (e.g. rongoā, listening to their body and being with whānau) were disregarded or misinterpreted by healthcare professionals. Additionally, previous negative experiences resulted in Māori patients feeling unable to talk freely with health workers, particularly concerning tikanga Māori-based approaches to wellbeing (tikanga Māori: customary system of values and practices). These more current experiences do not exist in a vacuum but are highly congruent with historical and collective memories of past events of racialised and patronising treatment. Contributing to this overlapping of present and past events is the bodily memory embodied in responses to smells and sounds.[43] The visceral response to the physical environment of the hospital setting, for example, evokes memories of past hospital visits and folds time across generations. In this manner, the public healthcare system in Aotearoa New Zealand unwittingly continues to perpetuate historical trauma against Māori.[44]

Looking across the studies in our review, whānau are doing significant amounts of caring work, which contributes positively to outcomes for Māori patients. The support offered by whānau consistently matches barriers faced. That is, whānau members 'bridge the gap' between proffered healthcare and the care required to meet health needs. This level of support is typically unpaid and tends to go unrecognised and may even be devalued by health professionals. It also comes at a cost to whānau, with whānau members sacrificing time, money and their own emotional wellbeing in order to attend to the unwell person.[27,30,39] Health professionals and systems need to overtly recognise the contribution of whānau to positive health outcomes. Specific acts of recognition and affirmation, practical reimbursements in the form of parking chits and food vouchers for whānau, and intentional information provision would contribute significantly to a sense of value and reduce the financial strain whānau face.

Our findings are consistent with international literature detailing health outcomes for Indigenous people in colonised nations. That is, adequately addressing Indigenous health needs requires moving beyond individualistic approaches.[45,46] Tackling the wider issue of health equities for Indigenous peoples requires removing structural injustices,[47] eliminating deficit discourses[48] and providing ethical, respectful and culturally safe interventions.[48] Positive, non-racist experiences of healthcare with culturally competent staff lead to improved outcomes for Indigenous peoples.[47-50] Our review serves as a timely reminder of the need for those involved at all levels of public health service delivery to continue to develop their cultural competencies and capacity to provide culturally safe services for Indigenous population groups. While acknowledging the efforts that have been undertaken by individuals and organisations, sustained, consistent efforts are required to undo the impacts of colonialism and racism baked into health service provision in countries such as Aotearoa New Zealand.

Strengths and limitations

Much of the work conducted by Māori practitioners is not published in academic sources or accessible to wider audiences; the parameters of a systematic review are themselves a tool of colonial practice. We acknowledge this as a limitation of our review

alongside the narrow 20-year timeline. We recognise that there is a wider body of grey literature that supports and extends the results from the included studies. Despite these limitations, identifying common themes across multiple studies in varying locales and diagnoses highlights key issues while emphasising opportunities for reducing health inequities. A key strength of our paper is that we consider the experiences of 326 Māori patients and their whānau. Our examination considered similarities of experience occur across time, diagnosis and location; there were strong commonalities of experience beyond individual studies. Observing issues raised over time and space is a key strength of secondary analysis[51] and is particularly useful when considering issues within and across cultures.[52]

Implications for public health practice

Through the process of undertaking this review, it became clear that for many Māori the existing public health system is experienced as hostile and alienating. While some individual health practitioners do their best to interact in supportive ways, such instances are experienced as conspicuously noticeable. The responses of Māori patients and their whānau in a modern-day context must be considered within the wider context of the collective memory of multiple decades of second-rate treatment, active discrimination and patronising interactions. Greater efforts need to be taken to ensure that tikanga Māori practices are supported within mainstream healthcare systems. Furthermore, healthcare environments and staff must recognise the many ways in which Māori care for their health and understand the influence of historical and intergenerational trauma in the here and now. This systematic indicates that there is still much work to be done within the current public health system to ensure that Māori consistently experience positive, high-quality interactions that support Māori ways of being.

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